

Too big, too young, too risky: How diagnosis of the foetal body determines trajectories of care for the pregnant woman in pre-viability second trimester pregnancy loss

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Abstract

Women in the English National Health Service facing pre-viability second trimester pregnancy loss through foetal death, premature labour or termination of pregnancy for foetal anomaly find themselves in a particular trajectory of care. This usually involves the requirement to labour and birth the foetal body and may involve undergoing feticide in cases of termination. Drawing on ethnographic research investigating women's experiences of second trimester pregnancy loss, I argue that the determining factor affecting care trajectories for the pregnant body is the biomedically diagnosed status of the foetal body. Foetal size, non-viability and the potential for live birth during terminations all structure the healthcare options for the woman facing pregnancy loss in the second trimester. As such, the diagnostic classification of the foetal body in the context of gestational time determines the medical care afforded to the pregnant body. This results in specific consequences for women, whose experiences of, and choices around, second trimester pregnancy loss are constrained by diagnostic and classificatory decisions around the status of the foetal being before legal viability.

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feticide, foetal body, pregnancy loss, pregnant body, second trimester, viability

INTRODUCTION

In biomedicine, the continuum of pregnancy is divided into three gestational time categories, called trimesters (National Health Service [NHS], ND; Royal College of Obstetricians and Gynaecologists [RCOG], 2021). These trimesters intersect with another classificatory division of the period of gestation in England: that of legally defined foetal viability. Viability is the point at which the human foetus is considered capable of separate life outside the body of the pregnant woman and acts as a threshold for a scientific and medical understanding of the foetus as a separate being (Franklin, 1991). It developed through English law subsequent to the criminalisation of abortion by the 1861 Offences Against the Person Act and was defined and refined by the 1929 Infant Life (Preservation) Act, the 1967 Abortion Act, the 1990 Human Fertilisation and Embryology Act and legislation related to stillbirth, such as the 1926 and 1953 Births and Deaths Registration Acts and the 1992 Still-birth (Definition) Act. Since 1990, the legal viability threshold in England is set at 24 weeks' gestation, towards the end of the second trimester, and prior to viability, the foetal body is legally understood to be part of the pregnant body (Pfeffer & Kent, 2007).

If a pregnancy does not reach full term, a combination of trimester categories and the threshold of viability means different classifications of its outcome will apply. These classifications are produced through biomedical assessment and diagnostic classification, in combination with the legal viability threshold, and whether the foetal being was born alive. In England, a biomedically confirmed live birth at any gestation results in a specific outcome of legal personhood. Where there is no live birth, other classifications of the ending of a pregnancy come into play. For example, a non-live birth in a spontaneous pregnancy loss or termination in England after the 24-week viability threshold is classified as a stillbirth, with a particular set of legal outcomes regarding civil registration and maternity rights. By contrast, a non-live birth in a spontaneous pregnancy loss before 24 weeks is classified as a miscarriage (RCOG, 2011b). Similarly, exceptions to the illegality of abortion can be certified by doctors on multiple grounds in the first and second trimesters, as defined by the Abortion Act. However, after viability abortion is only permissible in cases of diagnosed serious foetal anomaly or threat to the life of the pregnant woman (RCOG, 2010). Biomedical diagnoses of the events and bodies of pregnancy loss interact with legal governance to produce different classifications of what has occurred.

This paper is concerned with pregnancy loss in the second trimester of pregnancy up to viability, between 13 completed weeks and 24 completed weeks of pregnancy (RCOG, 2011b). In it, I draw on sociological research into women's experiences of second trimester pregnancy losses in South West England, in which wanted or accepted pregnancies which ended in this gestational timeframe were conceptualised as pregnancy losses, whether the loss was spontaneous or induced as termination of pregnancy. The range of experiences included spontaneous miscarriages of foetal beings which had died before birth and spontaneous extremely premature deliveries of babies who briefly lived. They also included inductions of labour using mifepristone and/or misoprostol, to deliver a foetus diagnosed as having died in utero, or to end a pregnancy on the basis of a diagnosis of foetal anomaly under the Abortion Act. All the participants had undergone

labour and birth in the second trimester, which is the standard trajectory of care in the NHS (National Institute for Health and Care Excellence [NICE], 2008, 2019a; RCOG, 2010).

In this paper, I argue that biomedical diagnostic activity on the second trimester foetal body, in relation to gestational timeframes, legal time thresholds and its eligibility for termination of pregnancy for reasons of foetal anomaly results in specific 'trajectories of care' (Allen et al., 2004). Such trajectories are then enacted on the pregnant body. The consequences of these classificatory processes are that choice about how the loss experience is managed is restricted for women facing pregnancy loss in the second trimester in the English NHS. The salient aspects of the second trimester foetal body which are examined here are its size, its relationship to the 24-week viability threshold and the complications a possible live birth could cause in cases of termination for foetal anomaly. The paper seeks to contribute to the sociology of diagnosis and to the social science of pregnancy loss and reproduction, which has addressed issues of power and agency in pregnancy loss in English healthcare (Hey et al., 1989; Letherby, 1993; Lovell, 1983; Moulder, 1998).

CLASSIFICATION, DIAGNOSIS AND REPRODUCTIVE POLITICS

Mechanisms of classification create structure and meaning in social worlds (Bowker & Star, 2000; Durkheim & Mauss, [1903] 2010), setting boundaries between things which might otherwise be understood as on a spectrum, such as the trimesters in pregnancy. Classification can convey meaning, produce knowledge or make things happen (Bowker & Star, 2000). Within biomedicine, the core activity of diagnosis depends on the process of applying available classificatory categories in medical care (Blaxter, 1978), resulting in the labelling of medical conditions (Jutel & Nettleton, 2011), for example foetal anomaly, foetal death or the onset of labour. Such diagnostic classifications are concerned with normativity and deviations from the norm (Brown, 1995). Jutel (2011) shows how diagnostic classification also takes place within wider social contexts and norms, such as pre-existing socially defined classificatory categories which distinguish between miscarriage and stillbirth. She also describes how biomedical classificatory categories such as foetal viability are contingent on the availability of resources such as neonatal care. Furthermore, not only are diagnostic classifications potentially produced by access to resources, diagnosis can also result in differential access to medical resources, through gatekeeping around access to different forms of treatment (Brown, 1990), or the allocation of resources for different treatments (Brown, 1995). Diagnosis is thus political, an activity through which power relations can be perceived and produced (Jutel, 2011), as well as a biomedical process. It can set limits on agency, as I argue below with regard to pre-viable second trimester pregnancy loss and the choices available to pregnant women.

This is consistent with classic sociological work on the balance of power between medicine and lay society or patients (Conrad, 1992; Foucault, [1963] 2003; Zola, 1972), and specifically the medicalisation of pregnancy, childbirth and abortion (Arney, 1982; Oakley, 1984; Sheldon, 1997). Classification of the foetal body as gestationally between 14 and 24 weeks of pregnancy, the timeframe of interest here, takes place in the context of medicalised pregnancy (Duden, 1993; Rothman, 1993) in which the foetal body has become a subject of medical scrutiny and observation (see for example, Casper, 1998; Petchesky, 1987; Williams, 2005). Furthermore, time and its measurement and management is implicated in the social control of reproduction and reproductive politics, often through the foetal body. Franklin (1991) has

described how embryonic and foetal bodies are defined through teleological understandings of biological development and thresholds of putative independent foetal life such as viability, erasing the work of pregnancy in producing a social being as well as a biological one. Thomas (1992) noted the consequences for pregnant women of the convertibility of gestational time and normalised ultrasound measurements of the foetus in antenatal care. Simonds (2002) has described the obstetric management of pregnancy and birth in relation to standardised time as a process which disempowers labouring women. Similarly, the standardisation of pregnancy time as linear clock and calendar time has been analysed as a limitation on abortion provision in England and Scotland, both in terms of the risk of foetus nearing the legal limitations of viability and in terms of the presentation of later abortion procedures as riskier for the pregnant woman (Beynon-Jones, 2012, 2017). Moulder (1998) has critiqued the organisation of pregnancy loss services around categorisations of gestational time and whether the loss was spontaneous or induced, arguing this restricts choice for women. In this paper, I argue that classifications of gestational time in the English NHS are produced by diagnostic activities and technologies, namely ultrasound measurements, and these, therefore, come under the purview of the sociology of diagnosis. Diagnostic classifications of gestational time based on the foetal body also interact with other diagnostic assessments of the foetus, such as foetal death or foetal anomaly, and of the pregnant woman, such as whether she is in premature labour.

TRAJECTORIES OF CARE IN SECOND TRIMESTER PREGNANCY LOSS

Diagnosis has implications for treatment because once a diagnosis is arrived at, some action is expected as a consequence (Blaxter, 1978; Brown, 1995). The organisation of healthcare has been conceptualised in terms of *trajectories*: the processes of organisation and management of a medical situation, primarily engaged in by medical staff in relation to resources, but also including the patient's actions (Strauss et al., 1985; Wiener et al., 1979). Such trajectories are sometimes illness trajectories, in which different organisation of different resources is required for different illnesses (Strauss et al., 1985), connecting trajectories to diagnosis. However, trajectories are also found in medical situations not understood as illness per se, including the organisation of labour and birth as a birth trajectory (Wiener et al., 1979).

More recently, Allen et al. (2004) have refocused the concept of trajectories onto care rather than illness, with their concept of *trajectories of care*. Here, there is less focus on contingent disruptions to the trajectory and more focus on problematic issues embedded within the trajectory itself, for example when the trajectory is acceptable to carers but not patients (Allen et al., 2004). This is a useful concept for this paper because it echoes the politics of diagnosis in its concern with potential power relations, such as the limitation of patient choice. The trajectory of care concept also emphasises the importance of addressing the context of care and underlying linkages between events in a trajectory, in order to explain why the trajectories take the course they do (Allen et al., 2004). In this paper, I seek to explain how the key link in trajectories of care available to pregnant women experiencing pre-viability second trimester pregnancy loss is diagnosis of the foetal body. Others have noted that diagnostic classification of the foetal body in relation to time, especially with regard to viability, is significant in relation to the care which is then made available in the interests of the survival of that body (Christoffersen-Deb, 2012; Flessas & Jackson, 2018). However, I argue that in the case of pre-viable second trimester pregnancy loss,

it is the diagnostic activity in relation to the foetal body which determines trajectories of care for the *pregnant* body.

METHODS

This paper is based on sociological ethnographic fieldwork carried out in 2018 and 2019 for my doctoral research into women's experiences of second trimester pregnancy loss in South West England. This is a contribution to feminist reproductive politics investigating the consequences of biomedical and governance classifications of the second trimester foetus for women experiencing premature labour, foetal death or termination for foetal anomaly. Whilst situated in the sociology of reproduction, the wider project also draws on anthropology and science and technology studies to show how some women agentially use alternative ontological positions on personhood and kinship based on embodied experience to challenge biomedical and governance classifications of their pregnancy losses.

The ethnographic approach to the field was characterised by the open research question (Pelkmans, 2013), which sought to investigate women's experiences of second trimester pregnancy loss. Methods included ethnographic interviewing, participant observation at memorial events and sites, analysis of documents (such as the Acts of Parliament and medical guidelines referred to here) and the analysis of material culture, such as memorial items. Interviewing was understood to be ethnographic because interviews drew in aspects of participants' lives beyond the parameters of a standardised semi-structured interview study (Hockey, 2002; Hockey & Forsey, 2013; Skeggs, 2001). For example, interviews included memorial items, discussion of wider family history, discussion of memorial events and sites attended by participant and interviewer and the presence of other family members. Furthermore, some analytic ideas were discussed with participants during or after interviews. Interviews were understood as collaborative endeavours (Kelly, 2010; Kvale & Brinkmann, 2009) in which my own experiences of second trimester pregnancy loss were relevant and sometimes discussed (Oakley, 1981).

Interviews followed participants' storytelling to produce a transcribed account of each woman's experience of pregnancy loss. These texts were iteratively thematically analysed alongside knowledge from the multiple sources described above, in the tradition of ethnographic analysis (Buch & Staller, 2007; Hammersley & Atkinson, 2019) and other generic inductive qualitative models (Hood, 2013; Maxwell, 2013; Maxwell & Miller, 2008). I inductively identified conceptual and theoretical themes across the interviews and other data, in a feminist approach which paid attention to bodies, power and women's experience (Buch & Staller, 2007). Considering the second trimester as a classificatory category allowed analytic comparisons between experiences of foetal death, termination for foetal anomaly, and spontaneous premature labour. A sample of the interview data was initially fine-grain coded ($n = 11$), and then connections between the resultant codes were made in order to manually organise all the interview data into three organising themes: women's experiences during the medical response to their pregnancy loss, their experiences in relation to the governance of the loss (such as birth registration entitlements) and their agential responses to loss (such as family practices related to death). These organising themes were then further divided, and also connected, by sub-themes, which were both data and theoretically derived (such as the normativity of the foetal body, the agency of women, access to care or communication in healthcare). The themes were also noted in analysis of documents such as RCOG guidelines or abortion care practices. As such, the analysis involved both categorising strategies and connecting strategies in order to produce generalising theory as well as

retain context (Maxwell, 2013; Maxwell & Miller, 2008). This allowed me to perceive, through comparison and contrast, the general factors related to the diagnosis of a serious problem in the second trimester and the healthcare options offered to women. It also allowed me to perceive the consequences of these aspects of healthcare in women's lives through the connecting strategies in the analysis. Both elements are, therefore, presented in this article.

Participants were self-selecting, recruited primarily through online social media linked to my personal social media, establishing my accountability as a named researcher as part of my feminist ethics. However, this method may also have limited the sample, for example by excluding women who do not engage with social media. To address this, further recruitment was carried out with the assistance of two pregnancy loss charities. Participants were mostly White British ($n = 30$), reflecting the lack of cultural and racial diversity in South West England (Krausova & Vargas-Silva, 2013). All were in heterosexual relationships at the time of the pregnancy loss. These restricted demographic representations are limitations in the study. The age range of women at interview was 25–48. There was a broad range of occupations and educational levels. Most ($n = 20$) had no religion, with 4 active Christians, 2 non-practising Christians and others with various spiritual beliefs. The 31 women had experienced 34 second trimester pregnancy losses, including foetal death ($n = 12$), premature labour ($n = 12$) and termination for foetal anomaly ($n = 10$). Participants had also experienced pregnancies ending in live births ($n = 26$) and losses at other times in pregnancy ($n = 18$) and were able to make comparisons between them. Their second trimester losses had occurred between 2003 and 2019, with half in the last three years of the range ($n = 17$).

The research was approved by the University of X Ethics Committee based on best practice around informed consent and participation (Reference 201718-104), including sharing access to support organisations with participants as relevant. One important deviation from default practices in social science research was participant choice around anonymity. Automatic anonymity is not always the most ethical choice in research with marginalised participants (Kvale & Brinkmann, 2009), and pregnancy loss research has offered partial naming of participants (Healthtalk.org, 2019; Oakley et al., 1984; Peelen, 2009). I offered three options, including full participant anonymity, full use of real names and pseudonymisation in the body of the text alongside an acknowledgement list of real participant names and names of babies. The intention was to challenge the stigmatisation of pregnancy loss, to acknowledge the role of participants in the creation of knowledge, and to acknowledge the role of naming in the production of foetal personhood for some women in the study. Those women who requested some reference to real names are listed at the end of this paper.

Findings

In the analysis, I discuss three specific diagnosis-related features of the second trimester foetal body affecting the trajectory of care offered to the pregnant woman experiencing pregnancy loss in the English NHS. Firstly, the larger size of a second trimester foetal body, as assessed in my research by a process of diagnostic classification based on ultrasound measurements related to normalised gestational time, means that surgical removal is usually not offered. The pregnant woman is required to labour and birth the foetal body. Secondly, the relationship of the second trimester foetal body to the legal foetal viability threshold means it is broadly considered too young to survive independently outside the pregnancy. This means a Caesarean section, with its risks to the pregnant woman, is considered inappropriate, and

again in most cases women must labour and birth the foetal body. Furthermore, the threshold of legal viability intersects with diagnosis of live birth and the consequent attribution of legal personhood in England. I argue that where a second trimester live birth could be risky, in cases of termination for diagnosed foetal anomaly, then the medical procedure of feticide, where the foetal heart is stopped before delivery, may be mandated. However, a woman in spontaneous labour at a similar gestation will not be offered feticide, and the 'risk' of live birth is considered not to require this trajectory of care. In each of these situations, diagnostic assessments and classifications of the foetal body determine the trajectory of care available to the pregnant woman, with significant consequences for them. The classifications are dependent on diagnosis in its broadest sense, embedded in wider values and resources, particularly those related to abortion law in England.

The foetal body as too big: Labour and birth because of foetal size

In the first trimester of pregnancy, the foetal body can be removed from the pregnant one through the cervix using surgical methods or vacuum aspiration, as well as through expectant or medical management (NICE, 2019b). In the second trimester, however, the foetal body is more substantial as gestational age progresses (Kiserud et al., 2017). Vacuum aspiration is not considered suitable in the UK after 16 weeks' gestation (RCOG, 2014, Lohr and Lyus 2014 2015), unlike in the USA (Ludlow, 2008). Alternative surgical methods are technically more complex in the second trimester, and the specialist skills required are in short supply both in the NHS and privately throughout the UK (NICE, 2019a; Purcell et al., 2014; RCOG, 2010; Speedie et al., 2014), where doctors can opt out of providing abortion care on grounds of conscience. In abortion, including termination for foetal anomaly, NICE (2019a) recommends that choice of medical or surgical management is offered to women but acknowledges that resources limit its availability. In cases of spontaneous intrauterine foetal death or pre-term labour in the second trimester before viability, NICE offers no alternative recommendations to expectant management or induction of labour (NICE, 2008, 2015). Access to those surgical resources which are available is based on gestational timeframes alongside categorisation as abortion. For abortion, in general, gestational age can be assessed by the woman's menstrual cycle dates (Jackson, 2001; RCOG, 2011a), giving some leeway in the application of timeframes. However, in termination for foetal anomaly, ultrasound is usually part of the diagnostic process regarding eligibility for this trajectory of care so gestational age is established in this process. Furthermore, by the second trimester most women have participated in NHS ultrasound 'dating' scans. For all the women in my study, therefore, gestational age was diagnosed, and fixed, by ultrasound measurement of the foetus, firmly placing them in the second trimester of pregnancy. This meant the trajectory of care available to them was most likely to be labour and birth, whether spontaneous or induced.

For almost all the participants, this requirement to labour and birth a second trimester foetus was unanticipated. All were aware of the possibility of surgical removal of the foetal body in the first trimester, and most assumed that something similar was available later in pregnancy. The mandating of labour and delivery was, therefore, experienced as shocking and disruptive. Paula¹ had prior experience of vaginal births and early miscarriage when foetal anomaly was diagnosed in her fourth pregnancy, and she decided to terminate the pregnancy at nineteen weeks' gestation:

I said to them, 'are you just going to take it away?'

And they were like, 'Oh, no, no, you've got to have a...you've got to come in and give birth.'

Was that a shock to you?

Yeah. [...] I'd probably say that that was the biggest shock. The realisation that I would have to go through childbirth. I'd have to deliver. And it just hadn't crossed my mind. I just thought that they would put me to sleep, deal with it, and then I would wake up and it would be all...gone, sort of thing.

Instead of an operation, Paula endured a slow, painful induction of labour, followed by manual removal of the placenta with an epidural. This removal of the placenta was incomplete, and a week later she woke in the night haemorrhaging and had to undergo surgical removal of retained placenta under general anaesthetic. Such complex trajectories of care were common in my research, unanticipated by the women involved, and involved considerable pain and distress.

For women facing decisions about termination for foetal anomaly earlier in the second trimester, time-sensitive trajectories of care linked to the size of the foetus defined by ultrasound measurements limited their choices. Joelle was told at the routine 12-week ultrasound scan that there was the possibility of a serious foetal chromosome disorder for which termination of pregnancy for foetal anomaly could be offered. Chorionic villus sampling was carried out, a diagnosis was made, and Joelle was offered a termination:

By that point I was almost 14 weeks. They said, 'if you, if you want the surgical termination, you need to do it this Friday.' ...and she was like, 'you need to let me know this afternoon because I need to get you booked in.' [crying].

So they didn't give me much time to decide. I said, 'I'm not, not really ready to make that decision.' So by that point I had to go for the induction.

In Joelle's case, resource availability combined with foetal size and gestational age determined the trajectory of care available to her once she felt able to make her decision. Her daughter was born at 16 weeks and died during the induced labour and birth. I asked Joelle if she thought it would have been easier if she had had surgical management of the termination:

Um...I don't know. I...I do appreciate the time that we got to spend with her. And originally we didn't even plan to see her or anything. And then, when it all happened, I had really bad haemorrhaging and really traumatic...I don't think they really tell you all the risks of things that can go wrong? Because I had a lot of retained placenta, I was really unwell for about 6 weeks afterwards.

The physical consequences of medical management of second trimester loss faced by Joelle were common in my research. Many of the women endured long and painful labours, and some lost large amounts of blood, with one needing an iron infusion and three needing blood transfusions as a consequence. Postnatal consequences could be serious too: at least 12 women had retained placentas and infections requiring surgery to remove pregnancy remains. In relation to termination, there is evidence of increased risk of some complications for pregnant women in medical management compared to surgical management (Comendant et al., 2014; Grimes, 2008;

Grossman et al., 2008; Lohr et al., 2008; Whitley et al., 2011), and as gestational time increases (RCOG, 2010), though NICE (2019a) considers differences in risk to be unclear in the second trimester. Whilst these studies relate to termination, it is reasonable to assume similar potential risk applies to other inductions carried out using the same medication in the second trimester, and some obstetricians argue surgical management is the safest method of all uterine evacuation (RCOG, 2019).

However, comparative risks are not spelled out to women in situations where there is no alternative trajectory of care available. For women facing termination for foetal anomaly in the second trimester, choice is not available in practice. For women facing intrauterine foetal death or irreversible premature labour, no alternative is offered to a trajectory of care involving labour and birth. Fiona's first baby died in utero, and the discovery was made in a private ultrasound scan at 16 weeks at which she had hoped to discover the baby's sex. She was then told by NHS doctors that they needed to induce delivery. Her sister suggested trying to access a surgical procedure through private healthcare, on the basis that it might be less traumatic:

I remember thinking, maybe I should, maybe that's better? I rang a private doctor and he said—I spoke to his secretary—long story short, eventually they phoned me back and said not at 16 weeks when I'd never had another baby, I needed to follow [NHS hospital]'s advice. Which then I thought, ok, I accept that. I understood the reasons why. Because your cervix has never opened.

The cervix not having previously opened would not preclude a woman having a second trimester surgical abortion under the Abortion Act for reasons other than foetal anomaly, which can be accessed through outsourcing from the NHS to private providers. However, it was used as a reason to persuade Fiona to accept induction in a case of foetal death. Generally, women were not offered a choice of trajectory of care, nor was a trajectory chosen because it carried fewest complications for their bodies. Instead, the trajectory of labour and birth in the second trimester came about as a result of medical diagnostic classification of the foetal body as too big for surgical removal via the cervix and vagina, in the context of limited resources in English healthcare.

The foetal body as too young: Labour and birth because of non-viability

The other factor determining a medical trajectory of care rather than a surgical one in second trimester loss is the development of the foetal body in relation to the 24-week viability threshold set by abortion law. In hospitals without advanced neonatal care facilities, there will be no attempt to preserve the life of a foetus born alive before viability, and in premature labour there is similarly no reason to perform a Caesarean section to try to save the foetus. In cases of foetal death, or termination, the consequences of birth for the foetal body are not relevant because it has died or will die. Medical management is the trajectory of care if the pregnant woman is considered physically able to labour.

Diagnostic classification of the foetal body, this time in relation to the gestational viability timeframe, puts women into a specific trajectory of care in circumstances of premature labour with a living foetus. Live birth is possible in the second trimester, although long-term survival is rare (RCOG, 2014), and four babies in this research were born after spontaneous second trimester premature labour before viability. The trajectory of care for all these pregnancies was labour and delivery, sometimes involving some induction. The role of viability in relation to the trajectory of

care offered to women in premature labour is best illustrated by the case of Charlie, who could compare her experiences of spontaneous premature labours either side of the 24-week viability threshold. In her first pregnancy, she went into labour at 23 weeks and 5 days' gestation. She described how being two days short of viability affected her and her unborn daughter's care in the non-specialist local hospital:

They tried to play with my dates, as far as they could, and they were like, 'there's no way we can get this pregnancy, like, above 24 weeks. You **are** 23 and 5.' Like, 'it is what it is, we can't get this pregnancy above, however we try, like growth scans, dates, she **is** just 23 and 5.'

In terms of intervening when she was born, was that?

Yeah. So they said—so this is when they said, and I remember this conversation like, like...it's probably the most graphic in my head. More than anything else. [crying].

She said: 'when this baby is born, you're going to have to hold her until she...sorry... until she passes.' [pause].

A combination of time and foetal size firmly categorised the baby as non-viable, despite staff's recognition of the distress this caused Charlie. Diagnostic classification of the foetal body structured the possibilities of care, and when it proved inflexible, so was the consequent trajectory of care.

After hours of painful labour, Charlie requested a Caesarean section:

At this point I was like 'give me a section, like, I don't even care!' But they don't like doing it for babies that have passed because they don't want the scar to remind you, [midwife] was saying they don't want the scar to remind you?

Like with Fiona, staff appear to have come up with an alternative rationale to stop Charlie requesting a different trajectory of care. Eventually, after a long and difficult labour, the baby girl was delivered in theatre using forceps, but she had died during the birth.

When Charlie became pregnant with her second daughter, it became clear this pregnancy was also under threat, and a cervical stitch was carried out to try to preserve it. However, infection was detected and it was decided that the baby would need to be born, this time at 24 weeks and 3 days, beyond viability. Charlie was treated at a specialist hospital with steroids and magnesium sulphate to attempt to reduce any damage to the baby's organs, and offered a Caesarean section with a paediatric team ready for resuscitation. On her lounge wall is a photo of this tiny baby being lifted alive from Charlie's body during the operation, her thin limbs stretched in the startle reflex:

Did the section, [baby girl] was born. She cried. So we were like 'she's crying, everything's going to be ok, she's crying!' [...] They were like 'congratulations, it's a beautiful baby girl, what do you want to call her?' And like, all the people were coming over and congratulating you, and like 'aww.' And it was just so nice. And then...like, she stopped crying. The cries stopped. [...] And then all of a sudden the whole room went silent. Like, eerily silent.

Charlie's second daughter had briefly lived before dying from infection, meaning her birth and death were registered, in contrast to Charlie's first daughter, officially diagnosed as a miscarriage. For Charlie, the few days separating her daughters' gestations had enormous consequences for the trajectories of care offered to them and to her. Such decisions about medical care of the foetus or baby are similar to those noted elsewhere (Christoffersen-Deb, 2012; Flessas & Jackson, 2018). However, my research shows the consequences are not only in relation to intervention on the foetal body, but also the trajectory of care available to the pregnant woman, and its consequences for her experience of medical care and of loss.

The foetal body as risky: limiting choice around feticide in the second trimester

Biomedical diagnosis of the foetal body is also instrumental in determining the use of another medical procedure, that of feticide. Feticide is carried out by the injection of potassium chloride into the foetal circulation through the pregnant woman's abdomen (Oloto, 2014; RCOG, 2010). Graham et al. (2008) argue feticide is a response to increased prenatal diagnosis of anomaly, the extension of termination for serious foetal anomaly beyond the viability threshold, and increasing survival rates of pre-24 week neonates. Feticide is, therefore, sometimes faced by women in the second trimester but would not be offered to women in the first trimester and would likely be mandated in a third trimester termination (NICE, 2019a). Guidance for doctors states:

The RCOG currently recommends feticide for terminations over 21+6 weeks. The only exception to this rule is when the foetal abnormality itself is so severe as to make early neonatal death inevitable irrespective of the gestation at delivery. (RCOG, 2010).

The vocabulary in the RCOG guidance is ambiguous in relation to whether the guideline is a 'recommendation', or a 'rule', and who decides this: Graham et al. (2008) suggest professional discretion, and Speedie et al. (2014) suggest women may decline it.

In my research, there was variation in who was offered feticide and who was given no option to either choose or reject it. Out of ten women who had terminations for foetal anomaly, three underwent the procedure, with a fourth having undergone it in a previous pregnancy. Of the three who underwent feticide in the second trimester, only one was offered a choice. Gemma's second daughter was diagnosed in pregnancy with a serious heart condition, and she and her husband decided to terminate the pregnancy:

Did they give you an option about the injection [to stop the foetal heart]?

No. They just said that that's what they did once the baby got to that gestation, because otherwise there was a chance she could be born and still alive initially. And then that...kind of...whether then there would be a decision as to whether they would try to keep her alive or not, or...so. Yeah, it was just kind of, that's what they did really. I was probably in shock at the time and I just kind of went with what they said.

That must have been distressing?

That was almost the hardest bit really. Obviously the labour and stuff was horrible, but you're kind of...in a lot of pain and everything as well, and there was things going on at that point. Whereas the injection you just lie there while they do it. Which I found really, really difficult. And then...yeah you sit in a little room [...] because they have to check you after half an hour and make sure the heartbeat has definitely stopped. You have to kind of sit in this little room drinking tea. And trying to—I don't know what we were talking about—trying to have a normal conversation, almost? Because you don't know what else to do. And then...go back and have another scan.

The manner in which feticide takes place, through the abdomen of the conscious pregnant woman, is a trajectory of care over which the woman herself may have very little agency. However, in some termination cases the RCOG guidelines appear to have been more flexibly interpreted. One woman was not offered feticide at all at 23 weeks after diagnosis of congenital abnormality. In other cases, women were offered feticide around 20 and 21 weeks but declined. Lucy, whose son was diagnosed prenatally with a serious heart defect, discussed feticide with doctors at 21 weeks but one suggested she might prefer a possible live birth and she decided against feticide. Her son was born alive and lived for a few hours, which the family welcomed.

Feticide in the second trimester is both a recommendation in some cases and a rule in others. Reasons for performing it identified elsewhere include avoiding a resuscitation dilemma for the pregnant woman and medical staff, avoiding the consequences of an unintended live birth that survives, and avoiding the possibility of a coronial inquiry into the death of a neonate (Oloto, 2014; Statham et al., 2006). However, there are further possible consequences of not performing feticide, such as the requirement for doctors to report an unsuccessful termination to the Care Quality Commission, the legal requirement to register live births and deaths, and, more remotely, the potential resource entitlements of maternity leave which can be claimed after any live birth. These factors suggest that it is less risky in terms of potential legal and bureaucratic consequences for caregivers to conduct a termination for foetal anomaly which does not end in a live birth.

For some pregnant women such as Gemma, this trajectory of care means feticide is mandated in terminations. In other cases in my research, women facing a possible live birth were not offered the procedure. None of the ten women who went into *spontaneous* premature labour with a foetus believed to be alive, rather than induced terminations, were offered feticide to prevent a live birth, and four experienced confirmed live birth. Feticide, therefore, cannot only be carried out to prevent the distress of live birth, or the resuscitation dilemma, or the possibility of early-term survival, since it does not always apply in terminations for foetal anomaly, nor does it apply in other second trimester cases where a live birth could occur. In my research the distress of the feticide itself was enduring for some women who underwent it, whereas the distress of a live birth and subsequent death was balanced by some acceptance or even satisfaction at having witnessed the living baby in all the other cases in my research. This contrasts with research which emphasises the acceptability of feticide to some parents, but in which parents seem to have been given choice (Graham et al., 2009). In my research, the decision about trajectories of care involving either feticide or live birth was not usually made by the pregnant woman, but by clinical staff, based on diagnostic assessment of the foetal body in relation to eligibility for termination for foetal anomaly. However, the consequences of this trajectory of care took place through and in the body of the pregnant woman.

CONCLUSION

The sociology of diagnosis calls for attention to the consequences of diagnosis in terms of resultant medical care (Blaxter, 1978; Brown, 1995), including in pregnancy situations such as foetal death (Jutel, 2011), and this article has used the concept of trajectories of care to show how diagnostic assessments and classifications of the foetal body in pre-viability second trimester pregnancy loss in England structure the treatments and forms of care available to pregnant women. It has also extended Jutel's interest in the consequences in the sociology of diagnosis to recognise a specific second order of consequence—the consequences of consequences—in its attention to the effects of trajectories of care in the lives of women such as Joelle, Charlie and Gemma. Trajectories of care derived from diagnostic activities which classify the foetal body as in the pre-viability second trimester reduce women's agency in this form of pregnancy loss. Women are generally unable to choose surgical management of their pregnancy loss. For almost all the women in this research, an alternative to labour and birth, and any comparative risks, was not presented at all, in a wider context of limited lay awareness of second trimester pregnancy loss. Some women facing termination for foetal anomaly were not able to decline the procedure of feticide. At the same time, for women facing premature labour the avoidance of live birth through feticide was not offered. These limited trajectories of care raise questions about informed consent and woman-centred care in pregnancy loss management. The article, therefore, contributes to the reproductive politics of pregnancy loss in England alongside the politics of diagnosis in its description of the limitations on women's agency, and the second-order consequences of this in their lives in terms of pain, postnatal complications and emotional distress.

The research reaffirms Jutel's (2011) emphasis on the importance of wider social context in the sociology of diagnosis when it shows how social and legal factors such as abortion law and viability thresholds affect diagnosis and trajectories of care in other forms of pregnancy loss. The focus on the pre-viability second trimester as a category of loss including foetal death, premature labour and termination for foetal anomaly allowed such novel analytic comparisons to be made across experiences. It also made visible how resource allocation and availability in the context of different diagnoses affects patient agency. Limited training in the NHS, and the option for medical staff to opt out of surgical abortion care has an impact not only on termination options for women but also on trajectories of care for foetal death in the second trimester.

The analytic emphasis in trajectories of care on common factors and problematic issues embedded within trajectories has also provided insight into the centrality and prioritisation of the foetal body in the management of second trimester pregnancy loss. Although legally the foetal body at this point in gestation is not a separate being but is considered part of the pregnant body, this paper shows how biomedical classifications related to diagnosis produce it as a separate body: too big, too young or too risky for particular trajectories of care. This extends the sociology of diagnosis literature in its attention to the consequences of diagnostic activities and trajectories of care which conceptualise foetal and pregnant bodies as clearly separated and distinct. It becomes clear that in such a conceptual framework it is possible to have one body as the site of diagnostic activity, with another body as the site of medical care. Focusing on which body is diagnosed, and with consequences for whom, is a potential new direction for the sociology of diagnosis in line with its interest in the politics of diagnosis (Jutel, 2011). At the same time, attention to diagnostic activity and its first- and second-order consequences has implications for reproductive politics when it provides an instance of the biomedical separation of foetal body and pregnant body into distinct medical objects.

Trajectories of care in second trimester pregnancy loss, despite the fact that the foetal being will not live, are nevertheless structured by attention to the foetal body rather than the agency and choice of the pregnant woman.

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Due to ethical concerns, participants did not consent to the sharing of their data, and as such the data supporting this publication are not publicly available.

AUTHOR CONTRIBUTION

Aimee Louise Middlemiss: Conceptualization (lead); Data curation (lead); Formal analysis (lead); Investigation (lead); Methodology (lead); Project administration (lead); Resources (lead); Software (lead); Writing-original draft (lead); Writing-review & editing (lead).

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ENDNOTE

¹ Participants have been pseudonymised in the text where they requested this, see Methods.

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